National Horsemen's Benevolent & Protective Association

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Written Statement of Philip Hanrahan, Chief Executive Officer of the National Horsemen's Benevolent and Protective Association, before the United States House of Representatives Energy and Commerce Committee, Subcommittee on Commerce, Manufacturing and Trade, regarding "H.R. 2012, a bill to improve the integrity and safety of interstate racing and for other purposes."

Mr. Chairman and other distinguished members of the Committee, I appreciate having this opportunity to testify today on behalf of the National Horsemen's Benevolent and Protective Association ("NHBPA"). The NHBPA, based in Lexington, Kentucky, has been representing the interests of thoroughbred horse owners and trainers racing in North America since 1940. There are over 29,000 owner and trainer members of the NHBPA throughout the United States and Canada focused on a twofold common goal: safe and fair horse racing on all levels and an unwavering commitment to the well being of race horses.

The NHBPA has 29 affiliates across the United States and Canada, including: Alabama, Arizona, Arkansas, British Columbia, Charles Town, WV, Colorado, Finger Lakes, NY, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Michigan, Minnesota, Montana, Mountaineer Park, WV, Nebraska, New England, Ohio, Oklahoma, Ontario, Oregon, Pennsylvania, Tampa Bay, FL, Texas, Virginia and Washington. Membership is open without restriction to all owners and trainers licensed by state racing authorities. From 2009 through 2011 owners spent over $2 billion to purchase race horses. They spent on average an additional $25,000 annually for the training and care of each horse.

The leadership of the NHBPA and its affiliates is democratically elected by the members. Ours is the largest organization in the United States representing owners and trainers of thoroughbred race horses. Other organizations that purport to speak for thoroughbred owners and trainers are not as representative or as inclusive as the NHBPA. The Jockey Club, headquartered in New York, is an invitation only organization that has approximately 100 members. The Thoroughbred Owners & Breeders Association ("TOBA"), located in Kentucky, has about 2,500 members, most of whom are horse breeders.

The NHBPA believes it helpful to again unequivocally and publically state its position on racing medication. The use of performance enhancing drugs has no place in horse racing. Owners and trainers who after a fair hearing are found to have cheated by administering drugs that have no legitimate therapeutic use in horses should be expelled from horse racing. Dermorphin, an opiate like substance derived from the skin of a South American frog that has been the subject of recent publicity, is one such drug. Blood doping, gene doping, and narcotics are other examples. Their intentional use is doping, and all doping should be penalized severely.

However, the NHBPA draws a clear distinction between illegal doping and lawful therapeutic medication that has long been used in horse racing by licensed veterinarians to maintain the health of racing horses and to treat injuries when they occur. Therapeutic medication, like furosemide (commonly called "Lasix") that acts to prevent and mitigate pulmonary hemorrhaging ("bleeding in the lungs") during racing, is necessary to keep a horse healthy and reduce the risk of injury to horse and jockey. Lasix use is not doping, and no one can reasonably conclude otherwise. Its use is safe and has been routinely administered by veterinarians for the past 40 years in their treatment of horses. Moreover, Lasix use is transparent to the public. In racing programs it is noted with "L" beside a horse's name.

The NHBPA supports the continued use of Lasix on race day and the use before race day of other recognized therapeutic medications like phenylbutazone, an anti-inflammatory equivalent to aspirin used by humans. We further support the application of science based medication thresholds to post race test samples to ensure that on race day no effective trace of therapeutic medication remains in a horse's system.

Turning to H.R. 2012, the NHBPA opposes its enactment because the bill attempts to address a problem that in reality does not exist, and purports to do so by employing an organization, the United States Anti-Doping Agency ("USADA"), which has neither the experience nor the resources to carry out a legislatively assigned task of regulating medication in the horse racing industry.

Medication rules and provisions for their enforcement, which H.R. 2012 seeks to create and implement on the federal level, already exist in every state that has horse racing with pari-mutuel wagering. Any asserted problem is one of misperception caused by recurrent sensationalism in the public media. News reports claim there is rampant illegal use of drugs in horse racing that state regulatory bodies are ignoring. However, an analysis of regulatory data in thoroughbred racing states shows that such assertions are flat out wrong.

Horse racing in the United States spends about $35 million a year on race day testing of horses. Racing has the longest in place and most comprehensive testing program of any sport in the world, and employs the most sophisticated and sensitive equipment found anywhere. In contrast, USADA, which conducts testing in human sports, stated in its 2012 annual report that it spent approximately $7.5 million on testing.

From 2009 through 2012, according to data maintained by The Jockey Club and data compiled by the Association of Racing Commissioners International from state racing commission records, 99.2% of 368,980 post race drug tests in thoroughbred races were negative for drug use. That rate of "clean tests" by no stretch of the imagination evidences a problem of rampant unregulated drug use. Quite to the contrary those results should be the envy of every other sport that tests for drugs.

In the 2009-2012 time frame there were some positive test results, but only a handful (142 out of 368,980 tests, or 3/100ths of 1%) were for illegal substances like dermorphin that serve no purpose other than to dope a horse to affect the outcome of a race. The vast majority of other positive results were for trace overages of lawful therapeutic medication, like common

anti-inflammatory drugs similar to Aspirin, Advil, and Aleve used in human sports. (The World Anti-Doping Agency does not prohibit use of non-steroidal anti-inflammatory drugs during competition because they are performance enabling, not performance enhancing.)

The following chart summarizes testing results for the 2009-2012 period. Class 1 and 2 positives, classified as such by the Association of Racing Commissioners International, are "cheater" drugs or "doping". Those drugs have the highest potential for affecting performance and have no generally accepted therapeutic medical use in race horses. Class 3, 4, and 5 positives, on the other hand, generally indicate overages of therapeutic medication permitted before race day. Furosemide (Lasix) is administered on race day to prevent and minimize bleeding in the lungs.

By regulation in every state therapeutic medications may be used in the days preceding a race, but not on race day, and have little or no likelihood of affecting performance. "No effect" threshold limits for therapeutics are set by state racing commissions so that on race day no horse is under the influence of any therapeutic medication, except for the race day use of Lasix.

Racing Medication Violation Data
2009-2012

State	Races	Starts	Avg. Field	Drug tests	Class 1	Class 2	Class 3	Class 4	Class 5	Furosemide	% Neg.	% Pos.
Arizona	6174	48685	7.88	12348	1	6	21	73	0	1	99.16	0.83
Arkansas	2051	18729	9.13	4102	2	0	1	14	0	6	99.44	0.56
California	17433	131019	7.51	34866	4	1	47	163	0	7	99.37	0.63
Delaware	3640	26889	7.38	7280	0	0	19	41	1	0	99.17	0.83
Florida	13255	113767	8.58	26510	0	3	44	151	15	1	99.19	0.81
Iowa	2443	18559	7.59	4886	2	0	1	1	0	0	99.92	0.08
Illinois	9010	72736	8.07	18020	0	5	28	72	1	14	99.34	0.66
Indiana	4388	37489	8.54	8776	1	0	11	28	0	10	99.44	0.56
Kentucky	8495	74081	8.72	16990	1	9	34	84	32	8	99.02	0.98
Louisiana	13692	123998	9.05	27384	11	2	30	328	2	22	98.57	1.43
Mass.	3255	25698	7.89	6510	0	3	7	5	0	0	99.77	0.23
Maryland	5627	43359	7.7	11254	0	2	10	21	3	4	99.65	0.35
Michigan	1619	11271	6.96	3238	0	0	0	12	0	0	99.55	0.45
Minnesota	1876	14581	7.77	3752	0	3	19	188	0	2	94.35	5.65
N. Dakota	331	2438	7.36	662	0	0	1	18	0	1	96.88	3.02
Nebraska	3278	26346	8.03	6556	4	0	33	70	0	0	98.37	1.63
NJ	3872	31155	8.04	7744	0	0	5	6	0	3	99.72	0.18
NM	6916	57062	8.25	13832	9	4	20	41	0	14	99.37	0.63
Nevada	162	806	4.97	324	0	0	0	3	0	0	99.08	0.92
New York	15037	116417	7.74	30074	0	3	16	27	0	6	99.83	0.17
Ohio	10458	78507	7.5	20916	0	5	29	176	44	12	98.73	1.27

Oklahoma	4560	42875	9.4	9120	22	0	8	55	2	4	99.01	0.99
Oregon	2993	21323	7.12	5986	0	1	2	54	0	2	99.02	0.98
PA	18027	145172	8.05	36054	9	10	29	227	5	40	99.12	0.88
Texas	4598	40494	8.8	9196	5	12	17	66	11	19	98.59	1.41
Virginia	1554	13018	8.37	3108	0	1	5	12	1	0	99.39	0.61
Wash.	3250	22410	6.89	6500	0	0	0	4	0	1	99.93	0.07
WV	16496	138323	8.38	32992	0	1	17	124	0	0	99.57	0.43
TOTAL	**184,490**	**1,497,207**	**8.11**	**368,980**	**71**	**71**	**454**	**2,064**	**117**	**177**	**99.2**	**0.8**

Clearly the state racing commission data above disproves dramatic allegations of widespread drug misuse. It also demonstrates that race day administration of Lasix is well regulated, with only 177 instances (0.04 or 4/100ths of 1%) in four years where Lasix was administered in an incorrect dosage or too close to post time. Even so, to avoid the appearance of any impropriety the National HBPA believes only state regulatory veterinarians, and not private veterinarians, should be permitted to administer Lasix on race day.

Unfortunately race day Lasix use, which H.R. 2012 ultimately prohibits, is being swept up in the hysteria over alleged doping of horses with illegal drugs, aided and abetted by individuals and organizations that should know better. Media reports calling for a ban on race day medication blur the line between what is permitted on race day (Lasix) and that which is not (all other therapeutic medication). This has obscured some basic scientific and medical facts, ignored by H.R. 2012, supporting continued use of Lasix:

- The extreme physical stress of hard running causes nearly all horses to bleed in their lungs, some more severely than others. Bleeding robs horses of oxygen, causes progressive and irreversible scarring in the lungs, makes breathing more difficult, and can cause instant death on the race track and endanger jockeys.
  (See attached: *Sudden death attributable to exercise-induced pulmonary hemorrhage in racehorses: Nine cases (1981-1983),* Diane E. Gunson, BVSc; Corinne Raphel Sweeney, DVM; Lawrence R. Soma, VMD)

- Nearly all bleeding remains internal and is only detectable by endoscopic examination. Detection by an externally visible nose bleed is the rare exception, but is usually the standard in Europe and Asia for determining whether a horse is a "bleeder."

- Lasix prevents and lessens bleeding. It is safe and has been used effectively for nearly forty years. Its regulated use does not prevent the post-race detection of other drugs. Similarly, research demonstrates Lasix does not cause a loss of bone density in horses leading to breakdowns.

- Lasix is not performance enhancing. It does not make a horse run faster than its natural talent. On the other hand, bleeding does make a horse run slower and can stop it outright.

Those individuals and organizations supporting federal regulation of racing medication often say we should emulate European racing, which they claim prohibits all drug use. That is not true. For example, horsemen in Britain are allowed to and do administer the same therapeutic medication used by American horsemen, including Lasix. The main difference in medication policy between the United States and Britain (as well as the rest of Europe) is the timing of Lasix use. In Britain Lasix is used in daily training to prevent or lessen pulmonary hemorrhaging, but not on race day. From a horse welfare standpoint that makes no sense. No one disputes that Lasix prevents injuries and fatalities in race horses and reduces risks for jockeys. Why not use it on race day when those risks are heightened?

On race day horses in Britain, like those in America (except for Lasix), may not compete under the influence of active medication. In the U.S. and Britain drug concentration thresholds are set to make sure lawful therapeutic medication used during training in the days that precede a race has no pharmacologic effect on race day. The British Horseracing Authority (BHA) uses post race testing, like we do, to ensure that is so.

The following chart, comparing four years of post race testing in Britain (based on the most recent data published by BHA) with the above data compiled by the Association of Racing Commissioners International, shows no significant difference in drug positive results between the two countries. Both are essentially drug free.

	Starts	**Tests**	**Negative**	**Positive**
Britain (2005-08)	381,002	36,511	99.86%	0.14%
United States (2009-12)	1,497,207	368,980	99.20%	0.80 %

The slight variance between countries may be accounted for by the fact that less than 10% of British starters are tested while the U.S. tests around 25% of all starters, and the U.S. has four times the number of starts. Also, the British select a single horse for post race testing subjectively based on performance in a race or "intelligence" available to the race stewards. In the U.S. selection in each race of two horses for testing is more or less random at the outset, ultimately including the winner and another horse selected by the stewards. In Britain only urine is routinely tested while in the U.S. both urine and blood are examined, with blood being the more accurate indicator of the presence of medication.

Advocates for British racing also point to the lower fatality, or breakdown rate, of horses racing in Britain compared to our horse industry experience. They claim, without any empirical evidence, that our higher fatality rate is caused by permissive drug use in U.S. racing. But as we have shown there is very little difference in medication policy, race day Lasix aside.

No one abhors racing fatalities more than the owners and trainers of those horses. We believe the cause of breakdowns in our industry is multi-faceted. Studies must continue to find ways to lessen fatalities. My personal view is that racing surfaces are a major cause of breakdowns (i.e., musculoskeletal injuries). In the U.S. most of our racing is on "dirt" tracks (actually a sand, clay, and loam mixture), many of which are hard, uneven, and inconsistent. It is not unusual to hear a horse took a "bad step" and was injured. Racing in Britain, on the other

hand, is on grass and to a lesser extent on artificial surfaces like polytrack, both of which are much easier on a horse because those surfaces provide more cushion for striking hooves and are more consistent. Horses in Britain also race fewer times annually than their American counterparts.

While the National HBPA opposes enactment of H.R. 2012 because it is unnecessary we do recognize the utility of uniform medication rules among the racing states. Medication use, post race thresholds, and penalties often vary from state to state. That makes it very challenging for owners and trainers in a mobile nation-wide industry, for example racing one week in Maryland and the next in Kentucky, to comply with different sets of rules. For that reason we are continuing to work with the Association of Racing Commissioners International on drafting model medication rules to recommend to the various racing jurisdictions. Nine states in the Mid-Atlantic including Delaware, Maryland, Virginia, Pennsylvania, New York, New Jersey, and West Virginia have taken the lead and have already approved uniform rules for medication regulation, enforcement, and laboratory testing like those drafted by ARCI. The same rules and procedures are currently under consideration in Arkansas, California, Florida, Idaho, Illinois, Indiana, Kentucky, Minnesota, New Mexico, Ohio, and Wyoming.

Significantly, ARCI's model rules, as well as those adopted in the Mid-Atlantic, permit Lasix use on race day. That is because scientific studies prove the efficacy of Lasix in treating exercise induced pulmonary hemorrhaging ("EIPH"), evidenced recently in the 2009 definitive South African study conducted by an international team of researchers, funded in part by The Jockey Club. (See attached)

The American Association of Equine Practitioners (AAEP) has also publically stated its support for Lasix noting that *"EIPH increases with age and exercise. One of the true values of furosemide* [Lasix] *is that the medication can be used to diminish or modulate the progressive pathologic change in the lungs that leads to repetitive bleeding.* (See attached)

The AAEP warns what is likely to happen if Lasix is not permitted on race day:

> *The racing industry should anticipate that other methods will be employed to reduce the incidence of EIPH if a race-day ban on Lasix is instituted. The practice of withholding food and water from the horse in the days leading up to a race should be expected. As doctors of veterinary medicine we believe that the detriments of withholding food and water to the health and welfare of the horse outweigh the current concerns about race-day Lasix administration.*
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> *The racing industry should also expect that unproven and perhaps undetectable products will be used in an attempt to alleviate EIPH on race day. Some of these products may include, but are not limited to, herbal remedies, nutraceuticals, and compounded medications that are not approved for use in the horse and have no scientific merit or efficacy in treating EIPH. The potential harmful side effects of these products to the horse are a serious concern.*

In short, the NHBPA submits there is no need for the federal government to reinvent the wheel by designating USADA to write and enforce uniform medication rules, particularly with a legislative fiat to ban Lasix. We have high regard for USADA's efforts in policing illegal drug use in human sports competition, but that organization has no expertise in equine veterinary science or experience in the horse racing industry of which we are aware. It would likely take USADA years to gain that knowledge and would require spending millions of dollars, in the long run most likely coming out of the pockets of horse owners and trainers, to create the infrastructure to write rules, to test horses racing across the country in over 45,000 races a year, and conduct enforcement proceedings for violations found. We note that in the 2009-2012 period charted above state racing regulators tested around 368,980 horses. During the same four year period USADA, according to its website, tested 33,309 human athletes, or less than 10% of the number of tests conducted by state racing commissions.

We conclude by stating our position regarding regulation of racing medication:

A) The National HBPA's focus has always been, and remains, the health and safety of the horse, the safety of the jockey, and the safety of all individuals coming into contact with the horse including grooms, hot walkers, trainers and veterinarians.

B) The National HBPA believes a truly independent and transparent Racing Medication and Testing Consortium ("RMTC") of industry stakeholders (including NHBPA, the Jockey Club, and TOBA, among others) not dominated by any individual organization, with input from appropriate medical and veterinary professional bodies such as the American Association of Equine Practitioners, must be the final evaluator of medical and veterinary science.

C) RMTC approved medication rules should be reviewed by the Association of Racing Commissioners International on behalf of state racing commissions, and following an evaluation based on science and medical research with all industry stakeholders being heard, the rules should be adopted or rejected by a majority vote.

D) Uniform medication rules must be based solely on published scientifically determined regulatory thresholds, with published scientifically determined withdrawal time guidelines, all based on and supported by data published in the scientific literature.

E) RMTC and ISO-17025 accredited laboratories should perform all medication testing.

F) Repeat offenders should be severely penalized, including permanent exclusion from the industry.